FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031385

Facility Name: SKOKIE MEADOWS N CENTER #1

Address: 9615 NORTH KNOX AVENUE (Number) SKOKIE (City) 60076 (Zip Code)

County: COOK

Telephone Number: (847) 679-4161 **Fax #** (847) 329-8633

IDPA ID Number: 36-3481217

Date of Initial License for Current Owners: 3/23/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JACOB GRAFF
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	113	Skilled (SNF)	113	41,245	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	113	TOTALS	113	41,245	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,318	3,318	8
9	SNF/PED					9
10	ICF	28,786	1,964	3,652	34,402	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,786	1,964	6,970	37,720	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.45%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

I. On what date did you start providing long term care at this location?

Date started 03/23/88

J. Was the facility purchased or leased after January 1, 1978?

YES [X] Date 03/23/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?

YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 3,318

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	256,997	13,533	9,147	279,677		279,677		279,677			1
2	Food Purchase		137,289		137,289		137,289	(22,338)	114,951			2
3	Housekeeping	123,797	19,064		142,861		142,861		142,861			3
4	Laundry	73,357	18,165		91,522		91,522		91,522			4
5	Heat and Other Utilities			117,122	117,122		117,122	99	117,221			5
6	Maintenance		18,686	47,658	66,344		66,344	(1,144)	65,200			6
7	Other (specify):*			7,605	7,605		7,605		7,605			7
8	**TOTAL General Services**	454,151	206,737	181,532	842,420		842,420	(23,383)	819,037			8
	B. Health Care and Programs											
9	Medical Director			1,100	1,100		1,100		1,100			9
10	Nursing and Medical Records	1,715,386	44,035	64,208	1,823,629		1,823,629		1,823,629			10
10a	Therapy	22,497		2,560	25,057		25,057		25,057			10a
11	Activities	88,199	9,105		97,304		97,304		97,304			11
12	Social Services	105,896		6,604	112,500		112,500		112,500			12
13	CNA Training											13
14	Program Transportation			610	610		610		610			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,931,978	53,140	75,082	2,060,200		2,060,200		2,060,200			16
	C. General Administration											
17	Administrative	75,095		237,663	312,758		312,758	(129,855)	182,903			17
18	Directors Fees											18
19	Professional Services			69,523	69,523		69,523	4,540	74,063			19
20	Dues, Fees, Subscriptions & Promotions			43,508	43,508		43,508	(32,612)	10,896			20
21	Clerical & General Office Expenses	106,256	12,727	232,149	351,132		351,132	(168,943)	182,189			21
22	Employee Benefits & Payroll Taxes			450,165	450,165		450,165	22,338	472,503			22
23	Inservice Training & Education			2,303	2,303		2,303		2,303			23
24	Travel and Seminar			4,034	4,034		4,034	(4,034)				24
25	Other Admin. Staff Transportation			10,935	10,935		10,935		10,935			25
26	Insurance-Prop.Liab.Malpractice			134,922	134,922		134,922	5,838	140,760			26
27	Other (specify):*							7,819	7,819			27
28	**TOTAL General Administration**	181,351	12,727	1,185,202	1,379,280		1,379,280	(294,909)	1,084,371			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,567,480	272,604	1,441,816	4,281,900		4,281,900	(318,292)	3,963,608			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: SKOKIE MEADOWS N CENTER #1 **#0031385** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,147	
	REPAIRS & MAINTENANCE		0	
			0	9,147
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		61,174	
	ELECTRICITY		31,840	
	WATER		18,290	
	CABLE TV - LOBBY		5,818	
			0	117,122
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		15,007	
	PAINTING & DECORATING		1,501	
	BUILDING REPAIRS		6,668	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		8,478	
	ELEVATOR MAINTENANCE & REPAIR		6,489	
	OUTSIDE LABOR		4,665	
	EXTERMINATING SERVICE		2,029	
	FIRE SERVICE		2,821	
			0	
			0	
			0	47,658
7	**OTHER**			
	SCAVENGER		7,605	
	SECURITY SERVICE		0	7,605
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,100	1,100

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		13,925	
	PURCHASED SERVICES		21,519	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,872	
	PHARMACY CONSULTANT	XVIII B 39-2	1,392	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	3,500	
	PSYCHIATRIC	XVIII B __-2	20,000	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	64,208
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	2,560	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	2,560
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	6,604	
			0	6,604
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 **#0031385** **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		610	610
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	237,663	237,663
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,092	
	ADMINISTRATIVE CONSULTANTS	XIX C	4,000	
	PROFESSIONAL FEES	XIX C	51,431	
			0	69,523
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	20,738	
	EMPLOYEE WANT ADS	XIX F	1,284	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	6,697	
	LICENSES & PERMITS	XIX F	2,915	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	10,349	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,525	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	43,508
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,181	
	EQUIPMENT REPAIR & MAINTENANCE		499	
	OUTSIDE CLERICAL SERVICES		194,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		11,469	
	MESSENGER SERVICE		0	
	OUTSIDE SERVICES		24,000	232,149

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	195,069	
	UNEMPLOYMENT COMPENSATION	XIX D	26,918	
	WORKERS COMPENSATION INSURANCI	XIX D	37,541	
	HOSPITALIZATION INSURANCE	XIX D	155,322	
	EMPLOYEE BENEFITS - OTHER	XIX D	8,838	
	EMPLOYEE PHYSICAL EXAMS	XIX D	500	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	25,977	
	CHICAGO HEAD TAX	XIX D	0	450,165
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,303	2,303
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	4,034	
			0	
			0	4,034
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		10,935	10,935
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		134,922	134,922
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,441,816

SKOKIE MEADOWS N CENTER #1
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	137,289	PATIENT MEALS	113160
LESS SALES TAX	0	ADD EMPLOYEE MEALS	21900
NET FOOD	137,289	TOTAL MEALS/YEAR	135060
TOTAL PATIENT CENSUS	37,720	NET FOOD	137289
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	135060
TOTAL PATIENT MEALS	113160	COST PER MEAL	1.02
		TIME EMPLOYEE MEALS	21900
ADD # EMPLOYEE MEALS/DAY	60		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	22338
TOTAL EMPLOYEE MEALS	21900		

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 #0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			36,163	36,163		36,163	109,862	146,025			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,761	37,761		37,761	468,232	505,993			32
33	Real Estate Taxes			283,119	283,119		283,119		283,119			33
34	Rent-Facility & Grounds			528,748	528,748		528,748	(528,748)				34
35	Rent-Equipment & Vehicles			40,235	40,235		40,235	2,409	42,644			35
36	Other (specify):* **amort.comp. soft.**			3,190	3,190		3,190		3,190			36
37	**TOTAL Ownership**			929,216	929,216		929,216	51,755	980,971			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		199,149	433,270	632,419		632,419		632,419			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,868	61,868		61,868		61,868			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		199,149	495,138	694,287		694,287		694,287			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,567,480	471,753	2,866,170	5,905,403		5,905,403	(266,537)	5,638,866			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	22,128	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,525)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(20,738)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(10,349)	20		28
29	Other-Attach Schedule	(225,359)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (235,843)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(30,694)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (30,694)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (266,537)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SKOKIE MEADOWS N CENTER #1

ID# 0031385

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (1,144)	6	1
2	BANK CHARGES	(2,181)	21	2
3	NON ALLOWABLE TRAVEL	(4,034)	24	3
4	OUTSIDE CLERICAL-PREMIER	(194,000)	21	4
5	OUTSIDE SERVICES-1139 BEVERLY	(24,000)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(225,359)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	99	0	0	0	0	0	0	0	0	0	99	5
6	Maintenance	(1,144)	0	0	0	0	0	0	0	0	0	0	(1,144)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,144)	99	0	0	0	0	0	0	0	0	0	(1,045)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(129,855)	0	0	0	0	0	0	0	0	0	(129,855)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,540	0	0	0	0	0	0	0	0	0	4,540	19
20	Fees, Subscriptions & Promotions	(32,612)	0	0	0	0	0	0	0	0	0	0	(32,612)	20
21	Clerical & General Office Expenses	(220,181)	51,238	0	0	0	0	0	0	0	0	0	(168,943)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,034)	0	0	0	0	0	0	0	0	0	0	(4,034)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	978	4,860	0	0	0	0	0	0	0	0	5,838	26
27	Other (specify):*	0	7,819	0	0	0	0	0	0	0	0	0	7,819	27
28	**TOTAL General Administration**	(256,827)	(65,280)	4,860	0	0	0	0	0	0	0	0	(317,247)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(257,971)	(65,181)	4,860	0	0	0	0	0	0	0	0	(318,292)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	22,128	0	87,734	0	0	0	0	0	0	0	0	109,862	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	468,232	0	0	0	0	0	0	0	0	468,232	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(528,748)	0	0	0	0	0	0	0	0	(528,748)	34
35	Rent-Equipment & Vehicles	0	2,409	0	0	0	0	0	0	0	0	0	2,409	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	22,128	2,409	27,218	0	0	0	0	0	0	0	0	51,755	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(235,843)	(62,772)	32,078	0	0	0	0	0	0	0	0	(266,537)	45

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACOB GRAFF	100	SKOKIE MEADOWS I	SKOKIE	PREMIER		BOOKKEEPING
		MOMENCE MEADOWS	MOMENCE	MANAGEMENT	SKOKIE	MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 237,663	PREMIER MANAGEMENT		$	$ (237,663)	1
2	V	5	UTILITIES		PREMIER MANAGEMENT		99	99	2
3	V	17	OFFICER SALARIES		PREMIER MANAGEMENT		55,145	55,145	3
4	V	17	ADMINISTRATIVE SALARIES		PREMIER MANAGEMENT		34,709	34,709	4
5	V	17	ADMINISTRATIVE SALARIES		PREMIER MANAGEMENT		17,954	17,954	5
6	V	19	PROFESSIONAL FEES		PREMIER MANAGEMENT		4,540	4,540	6
7	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		19,344	19,344	7
8	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		15,175	15,175	8
9	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		13,015	13,015	9
10	V	21	OFFICE EXPENSE		PREMIER MANAGEMENT		3,704	3,704	10
11	V	26	INSURANCE		PREMIER MANAGEMENT		978	978	11
12	V	27	PAYR.TAXES/HEALTH INS		PREMIER MANAGEMENT		7,819	7,819	12
13	V	35	OFFICE RENTAL		PREMIER MANAGEMENT		2,409	2,409	13
14	Total			$ 237,663			$ 174,891	$ * (62,772)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 528,748	M O SKOKIE MEADOWS		$	$ (528,748)	15
16	V	26	INSURANCE				4,860	4,860	16
17	V	30	DEPRECIATION				87,734	87,734	17
18	V	32	INTEREST				468,232	468,232	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 528,748			$ 560,826	$ * 32,078	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACOB GRAFF	PRESIDENT	ADMINISTRATIV	100.00	SEE ATTACHED	SEE ATTACHED		SALARY	$ 55,145	17-7	1
2			BANKING								2
3			FINANCE								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 55,145		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREMIER MANAGEMENT
Street Address: 9933 N. LAWLER
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 679-7733
Fax Number: (847) 679-7736

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	342,006	8	$ 900	$	37,720	$ 99	1
2	17	OFFICER SALARIES	PER RESIDENT DAY	342,006	8	500,000	500,000	37,720	55,145	2
3	17	ADMINISTRATIVE SALARIES	DIRECT	10	3	115,696	115,696	3	34,709	3
4	17	ADMINISTRATIVE SALARIES	PER RESIDENT DAY	342,006	8	162,786	162,786	37,720	17,954	4
5	19	PROFESSIONAL FEES	PER RESIDENT DAY	342,006	8	41,168		37,720	4,540	5
6	21	CLERICAL SALARIES	DIRECT	10	3	48,360	48,360	4	19,344	6
7	21	CLERICAL SALARIES	DIRECT	4	3	60,700	60,700	1	15,175	7
8	21	CLERICAL SALARIES	DIRECT	10	4	43,384	43,384	3	13,015	8
9	21	OFFICE EXPENSE	PER RESIDENT DAY	342,006	8	33582		37,720	3,704	9
10	26	INSURANCE	PER RESIDENT DAY	342,006	8	8,869		37,720	978	10
11	27	PAYR.TAXES/HEALTH INS	PER RESIDENT DAY	342,006	8	70,898		37,720	7,819	11
12	35	OFFICE RENTAL	PER RESIDENT DAY	342,006	8	21,844		37,720	2,409	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,108,187	$ 930,926		$ 174,891	25

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: M O SKOKIE MEADOWS NURSING
Street Address: 9615 N KNOX
City / State / Zip Code: SKOKIE,IL 60076
Phone Number: (847)679-7733
Fax Number: (847)679-7734

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	INSURANCE	DIRECT	1	1	$ 4,860	$	1	$ 4,860	1
2	30	DEPRECIATION	DIRECT	1	1	87,734		1	87,734	2
3	32	INTEREST	DIRECT	1	1	468,232		1	468,232	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 560,826	$		$ 560,826	25

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CAMBRIDGE		X	MORTGAGE	$44,062.00	8/16/01	$ 6,822,050	$ 6,602,627	8/16/36	0.0710	$ 468,232	1
2												2
3												3
4												4
5												5
	Working Capital											
6	1ST EQUITY		X	WORKING CAPITAL	INT ONLY			646,327			37,761	6
7												7
8												8
9	TOTAL Facility Related				$44,062.00		$ 6,822,050	$ 7,248,954			$ 505,993	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,822,050	$ 7,248,954			$ 505,993	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 **#** 0031385 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 201,402	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 242,260	2
3. Under or (over) accrual (line 2 minus line 1).	$ 40,858	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 242,261	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 283,119	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	176,544	8
2001	156,179	9
2002	159,393	10
2003	201,402	11
2004	242,261	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SKOKIE MEADOWS N CENTER #1 COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031385

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-10-304-007-0000	NURSING HOME	$ 40,372.91	$ 40,372.91
2.	10-10-304-008-0000	NURSING HOME	$ 40,377.53	$ 40,377.53
3.	10-10-304-009-0000	NURSING HOME	$ 40,377.53	$ 40,377.53
4.	10-10-304-010-0000	NURSING HOME	$ 40,377.53	$ 40,377.53
5.	10-10-304-011-0000	NURSING HOME	$ 40,377.53	$ 40,377.53
6.	10-10-304-012-0000	NURSING HOME	$ 40,377.53	$ 40,377.53
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 242,260.56	$ 242,260.56

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,048 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING		1990	$ 347,575	1
2					2
3	TOTALS			$ 347,575	3

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	113		1990		$ 1,968,925	$ 62,506	31.5	$ 62,506	$	$ 898,542	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENT			1987	4,888	155	20	155		3,992	9
10	IMPROVEMENT			1988	3,196	101	31.5	101		1,792	10
11	IMPROVEMENT			1990	29,530	937	31.5	937		14,107	11
12	IMPROVEMENT			1991	20,962	665	31.5	665		9,672	12
13	IMPROVEMENT			1992	18,635	593	31.5	593		7,959	13
14	IMPROVEMENT			1993	50,200	1,594	31.5	1,594		20,515	14
15	IMPROVEMENT			1993	8,052	206	39	206		2,549	15
16	IMPROVEMENT			1994	71,864	1,843	39	1,843		21,310	16
17	FIRE DAMPERS			1995	4,980	128	39	128		1,392	17
18	NURSE STATION REMODELING			1995	70,129	1,798	39	1,798		18,805	18
19	CONCRETE WORK, PATIO, RAMPS			1995	21,904	1,460	39	1,460		15,513	19
20	RESIDENT ROOM REMODELING			1996	25,459	653	15	653		6,285	20
21	ROOF			1996	1,200	31	39	31		310	21
22	REHABBING 1ST FLOOR CORRIDOR LOWER WALLS			1997	14,497	372	39	372		3,178	22
23	DOOR			1997	1,455	37	39	37		331	23
24	ELEVATOR RENOVATION			1997	14,791	379	39	379		3,079	24
25	FIRE DAMPERS			1998	7,282	187	39	187		1,472	25
26	EXHAUST FANS			1998	4,135	106	39	106		811	26
27	FIRE DAMPERS & 21 GRILLS			1998	22,408	575	39	575		4,381	27
28	ACCESS PANELS & FIRE DAMPERS			1998	2,720	70	39	70		499	28
29	TILING			1999	14,344	368	39	368		2,407	29
30	KIL-BAR			1999	3,587	92	39	92		602	30
31	WALL HEATERS			1999	6,392	164	39	164		1,073	31
32	DOOR			1999	1,190	30	39	30		197	32
33	WINDOW REPLACEMENT			1999	61,410	1,575	39	1,575		10,303	33
34	SHOWER ROOM TILING			1999	9,206	236	39	236		1,544	34
35	GENERATOR			2000	62,880	2,287	27.5	2,287		12,578	35
36	TILING			2000	6,052	220	27.5	220		1,210	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WALL COVERING	2000	$ 33,819	$ 3,017	7	$ 4,831	$ 1,814	$ 30,281	37
38	AWNING	2001	2,951	107	27.5	107		486	38
39	CORNICES	2001	1,741	63	27.5	63		286	39
40	ROOF	2001	50,988	1,854	27.5	1,854		8,420	40
41	DOOR	2001	2,160	79	27.5	79		359	41
42	ELEVATOR DOOR	2001	10,450	380	27.5	380		1,726	42
43	TWO DECK ROOFS	2001	12,100	440	27.5	440		1,998	43
44	5 TON CONDENSING UNIT	2001	2,854	104	27.5	104		472	44
45	WALLPAPERING, PAINTING	2002	60,000	4,838	5	12,000	7,162	42,000	45
46	FLORIDA SMOKING ROOM	2002	27,967	1,017	27.5	1,017		3,602	46
47	DUCTLESS SPLIT ROOM	2002	12,377	450	27.5	450		1,594	47
48	VALVE	2002	2,160	78	27.5	78		277	48
49	SIGN	2002	2,450	163	15	163		571	49
50	SHEET LEAD SHOWER LINER PANS	2002	5,471	199	27.5	199		705	50
51	SHOWER BASIN TILING	2002	15,498	564	27.5	564		1,997	51
52	PAVING PARKING LOT	2002	12,495	833	15	833		2,915	52
53	CONCRETE FOOTINGS, WALLS, STEPS,	2002	29,975	1,090	27.5	1,090		3,860	53
54	COOLER DOOR	2002	3,772	137	27.5	137		485	54
55	SIGN	2002	4,590	306	15	306		1,071	55
56	TUCKPOINTING	2002	24,600	894	27.5	894		3,167	56
57	4 TON CONDENSING UNIT	2002	4,800	175	27.5	175		619	57
58	VCT,COVE BASE	2003	4,639	168	27.5	168		427	58
59	ELEVATOR SAFETY EDGE	2003	1,575	58	27.5	58		147	59
60	NURSE CALL SYSTEM	2003	4,596	167	27.5	167		425	60
61	CARPET	2003	1,752	235	5	154	(81)	658	61
62	BLINDS	2003	2,648	251	5	530	279	1,590	62
63	CUBICLE CURTAINS, PAINTING,WALLPAPER	2003	5,805	560	5	1,161	601	3,483	63
64	INSTALL TRENCH DRAIN	2004	8,120	771	15	771		1,177	64
65	LIGHT FIXTURES	2004	9,188	334	27.5	334		515	65
66	REHAB ELEVATOR	2004	29,846	1,085	27.5	1,085		1,673	66
67	10 TON COOLING UNITS	2004	16,983	618	27.5	618		952	67
68	TILING, COVE BASE	2004	64,000	2,327	27.5	2,327		2,424	68
69	CEILINGS & LIGHTING	2004	51,173	1,861	27.5	1,861		1,939	69
70	TOTAL (lines 4 thru 69)		$ 3,055,816	$ 104,591		$ 114,366	$ 9,775	$ 1,188,709	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,055,816	$ 104,591		$ 114,366	$ 9,775	$ 1,188,709	1
2	WATER HEATER	2005	4,650	78	27.5	78		78	2
3	DRYWALL	2005	3,725	62	27.5	62		62	3
4	WALK IN COOLER CONDENSING UNIT	2005	7,343	122	27.5	122		122	4
5	RESURFACING FRONT WALLS	2005	12,800	640	15	640		640	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,084,334	$ 105,493		$ 115,268	$ 9,775	$ 1,189,611	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 328,029	$ 14,869	$ 29,873	$ 15,004	10	$ 234,894	71
72	Current Year Purchases	17,676	3,535	884	(2,651)	10	884	72
73	Fully Depreciated Assets	455,600					455,600	73
74								74
75	TOTALS	$ 801,305	$ 18,404	$ 30,757	$ 12,353		$ 691,378	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,233,214	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,897	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 146,025	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 22,128	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,880,989	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 528,748			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 528,748 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 23,132 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	2002 ECOCO VAN E350	$ 555.00	$ 7,933	17
18	DON	2001 ILDS ALERO	472.00	4,721	18
19	ADMINISTRATOR	2006 CAD CTS	449.00	4,449	19
20					20
21	TOTAL		$ #######	$ 17,103	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 181,973	$		$ 181,973	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			47,660			47,660	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			194,972			194,972	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				199,149		199,149	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-8				8,665			8,665	13
14	TOTAL			$		$ 433,270	$ 199,149		$ 632,419	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 **#** 0031385 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,614,781	$	1
2	Cash-Patient Deposits	3,457		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,136,135		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,770		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,821,143	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	448,037		15
16	Equipment, at Historical Cost	174,548		16
17	Accumulated Depreciation (book methods)	(178,275)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spc **Construction Progres**	25,475		22
23	Other(specify): **Due From Related Parties**	7,412,409		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,882,194	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,703,337	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 154,439	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,329,163		29
30	Accrued Salaries Payable	139,401		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	242,261		32
33	Accrued Interest Payable	2,975		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,868,239	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,496,265		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,496,265	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,364,504	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,338,833	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,703,337	$	48

***(See instructions.)**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,623,889	1
2	Restatements (describe):		2
3	**Skokie 2 Eliminiation Entry & Post Closing Entry**	84,395	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,708,284	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(369,451)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (369,451)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,338,833	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,193,271	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,193,271	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	341,538	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 341,538	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,143	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,143	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,535,952	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	842,420	31
32	Health Care	2,060,200	32
33	General Administration	1,379,280	33
	B. Capital Expense		
34	Ownership	929,216	34
	C. Ancillary Expense		
35	Special Cost Centers	632,419	35
36	Provider Participation Fee	61,868	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,905,403	40
41	**Income before Income Taxes (line 30 minus line 40)****	(369,451)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (369,451)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
tax return is a combination of mo skokie, and skokie 1 & 2

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	6,719	7,143	$ 239,175	$ 33.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,648	31,771	837,757	26.37	3
4	Licensed Practical Nurses	603	610	14,232	23.33	4
5	CNAs & Orderlies	58,555	62,758	624,222	9.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,614	1,906	22,497	11.80	8
9	Activity Director					9
10	Activity Assistants	8,614	8,559	88,199	10.30	10
11	Social Service Workers	3,955	4,203	105,896	25.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,402	22,777	256,997	11.28	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	9,941	10,670	123,797	11.60	18
19	Laundry	14,651	16,393	73,357	4.47	19
20	Administrator	2,272	2,472	75,095	30.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,243	8,838	106,256	12.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,217	178,100	$ 2,567,480 *	$ 14.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly Fees	$ 9,147	1-3	35
36	Medical Director	Monthly Fees	1,100	9-3	36
37	Medical Records Consultant	Monthly Fees	3,872	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly Fees	1,392	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	Monthly Fees	6,604	12-3	45
46	Other(specify) REHABILITATION	Monthly Fees	2,560	12-3	46
47	PHYSICIANS	Monthly Fees	3,500	10-3	47
48	PSYCHIATRIC	Monthly Fees	20,000	10-3	48
49	TOTAL (lines 35 - 48)		$ 48,175		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RUDULPH STERNSCHGN	ADMIN		$ 75,095
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,095

B. Administrative - Other

Description	Amount
PREMIER MANAGEMENT - MANAGEMENT FEES	$ 237,663
TOTAL (agree to Schedule V, line 17, col. 3)	$ 237,663
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		69,523
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 69,523

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 37,541
Unemployment Compensation Insurance		26,918
FICA Taxes		195,069
Employee Health Insurance		155,322
Employee Meals		22,338
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		8,838
EMPLOYEE PHYSICAL EXAMS		500
PENSION/PROFIT SHARING PLANS		25,977
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 472,503

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,284
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	31,087
TRUST/FRANCHISE/CONTRIB/ETC	1,525
LICENSES & PERMITS	925
DUES & SUBSCRIPTIONS	6,697
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(1,525)
Less: Public Relations Expense	(0)
Non-allowable advertising	(20,738)
Yellow page advertising	(10,349)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,896

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINTING/DECORATIC	2001	$ 4,429	3 YRS	$ 1,477	$ 1,477	$ 736	$	$	$	$	$	$
2	PAINTING/DECORATIC	2002	642	3 YRS	107	214	214	107					
3	PAINTING/DECORATIC	2005	1,501	3 YRS				250	500	500	251		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,572		$ 1,584	$ 1,691	$ 950	$ 357	$ 500	$ 500	$ 251	$	$

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM $4916**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **61,868**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **22,338** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees